Date of Service:	CPT/HCPCS Code:	Location	n: *	Group Formula				
MM/DD/YY				# Min	nutes X	#Staff /	# Clients =	
Provider Staff ID:	Provider Co-Staff ID:		Face HR:	to Face Time: MIN: Total Time: HR: MIN:		e:		
Focus of Treatment:	(a).	T/			a (a):			
DSM-IV-TR Diagnosis Code(Affect/Mood: Appropriate				Billing Coderance:		Disheveled	Malodorous	
☐ Elevated ☐ Anxious	☐ Irritable ☐ Depr	essed						
☐ Restricted ☐ Labile [Incongruent							
Other:								
Orientation: ☐ Person ✓=Yes	Place Day	Time Current Situation All Normal Month Year						
Precipitators/Recent Stressors: No Yes Describe:								
Safety Issues: No S	Yes Describe:							
Safety Issues. [110]	Safety Issues. NO Les Describe.							
Review of Group (include client's complaints/symptoms/focus of group/interventions):								
Dragnass Towards Massural	ala Caala/Ohiaatiyası							
Progress Towards Measurable Goals/Objectives:								
Changes to Plan of Care Ind Plan:	icated? Tes No							
1 1011.								
Signature/Title/Credential Date			Printed Name					
Co-Signature/Title/Credential	Date		Printed Name					
* 1-Office, 2=Field, 3=Phone,	4=Home, 5=School, 6=	Satellite,	7=Cri	sis Field, 8=.	Jail, 9=Inp	atient		
County of San Diego		Client:						
Health and Human Services Agency Mental Health Services								
CDOUD DDOCDESS NOTE		MR/InSyst #:						
GROUP PROGRESS NOTE		RU/Program:						